WOMEN'S HEALTH, MATERNITY UNIT
Neonatal Intensive Care Guideline, Paediatrics

GUIDELINES FOR THE DELIVERY OF EXTREMELY PREMATURE BABIES

Amendments

<table>
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<tr>
<th>Date</th>
<th>Page(s)</th>
<th>Comments</th>
<th>Approved by</th>
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<tbody>
<tr>
<td>24/04/07</td>
<td></td>
<td>Complete document review</td>
<td>Women’s Health Clinical Governance Committee in conjunction with the neonatal consultants</td>
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Volume
Maternity Guidelines
Section P1
First Ratified September 2002
2nd Ratified April 2007
3rd Ratified March 2011
Last Reviewed November 2014
Issue 3
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When a baby is born at the threshold of viability (defined as being 22 to 26 weeks gestation, BAPM 2000) it is essential that the baby is offered an appropriate level of care, and where possible the parents are appropriately counselled before delivery. In this unit it has been agreed that the paediatric team (lead by the neonatal consultant or registrar) will attend deliveries from 23rd-gestation and that mothers should receive both antenatal steroids (for fetal lung maturation) and magnesium sulphate (for neonatal neuroprotection) if possible from 23+0 weeks. If delivery is anticipated at or beyond 23 weeks then the paediatric team will be asked to counsel the parents before delivery, where practical. Obviously the paediatric registrar must be informed of any woman thought to be labouring at this gestation, even if they do not see them before delivery. It should be recognised that unfortunately only 7% of babies born between 23rd and 23rd will survive (The EPICure study: 2000).

Babies born at or below 22+6 weeks are unfortunately not destined to survive, though may be born live. Doctors and midwives caring for women likely to deliver at this gestation should compassionately discuss this with the parents, and not give them the impression that the baby is likely to be “resuscitated”, but should of course be given “comfort care”. Clearly it is not appropriate that the baby does not receive any care (Nuffield Guidelines: 2006).

For all cases it is important that a plan of care is documented in the woman’s maternity notes.

In general women expected to deliver at 22+6 or less will not be seen before delivery by the paediatric team. If however there are concerns that the gestation may be greater than this, or in the opinion of the midwives or obstetric consultant or registrar involved in her care that this is needed the shift leader may ask the neonatal consultant or registrar to come and see the parents before delivery.

Parents expecting delivery at 22+6 or less should be told that the baby may not survive labour, and that there is no advantage to listening to the fetal heart during labour. If the baby does not show any obvious visible signs of life (movement, breathing or crying) then there is no expectation that the baby’s chest will be listened to with a stethoscope. This baby will be classified as a late miscarriage, and does not require a stillbirth certificate.

If the baby is born at less than 23 weeks gestation with obvious visible signs of life the midwife should arrange for the neonatal registrar to be fast bleeped (2222), and asked to attend urgently. She should also take the baby to the resuscitaire, keep the baby warm and give it face mask oxygen. The neonatal registrar will then decide whether further active resuscitation is appropriate, usually it is not. If further active resuscitation is not offered the baby should be wrapped, and given to the parents if they wish. These babies may live for minutes or even a few hours. The parents clearly need compassionate support during this time.

The current law on stillbirth registration is set out in the Births and Deaths Registration Act 1953 (amended by the Still-Birth (Definition) Act 1992). The legal definition of stillbirth is: any child expelled or issued forth from its mother after the 24th week of pregnancy that did not breathe or show any other signs of life. Legal advisors for the Department of Health and the Office for National Statistics have agreed that a fetus that is expelled after 24 weeks of pregnancy, provided it was no longer alive at the 24th week of pregnancy (this fact being either known or provable from the stage of development reached by the dead fetus), does not fall within the category of births to be registered as a stillbirth under the above Acts. When the gestational age is not known before the birth, with unbooked pregnancies for example, the decision about the status of the birth should be made on the basis of the stage of development of the baby on examination. RCOG 2010.
When the midwife feels that the baby has died a neonatal or obstetric registrar should be asked to confirm death, and to complete the Death Certificate (usually the cause of death will be “extreme prematurity”). Obviously all live babies must be registered as live births, regardless of the gestation at birth.

Investigation and follow up after a very pre term delivery will depend upon the circumstances. If it is not clear from the notes whether post mortem or other investigation is required, and what follow up should be arranged then this should be discussed with the on-call consultant obstetrician (this can always wait until the morning).

This unit does not usually accept in-utero transfers for immediate delivery at less than 23+0 gestation. If transfer of care is requested before this gestation, consultant to consultant discussion is mandatory.

This guideline was agreed by the obstetric and neonatal consultants on 22nd March 2007.

References

EPICure Study: Outcomes to Discharge from Hospital for Infants Born at the Threshold of Viability (2000) Paediatrics, 106, 659-671


Nursing and Midwifery Council (January 2007) The care of babies born alive at the threshold of viability.

Royal College of Obstetricians and Gynaecologists (2010) Late Intrauterine Death and Stillbirth Green-Top Guideline No. 55

Reviewed November 2014
Inserted line about steroids and magnesium in line with current practice (Dr Peter Reynolds)
Next review Nov 2019
EQUALITY IMPACT ASSESSMENT TOOL

Name: Guideline for the delivery of extremely premature babies

Policy/Service: Maternity Services

Background
- Description of the aims of the policy
- Context in which the policy operates
- Who was involved in the Equality Impact Assessment

Guidance for staff when a baby is born at the threshold of viability. The policy operates within hospital maternity and neonatal services.

Methodology
- A brief account of how the likely effects of the policy was assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age)
- The data sources and any other information used
- The consultation that was carried out (who, why and how?)

No impact identified

Key Findings
- Describe the results of the assessment
- Identify if there is adverse or a potentially adverse impacts for any equalities groups

No impact identified

Conclusion
- Provide a summary of the overall conclusions

No impact identified
Recommendations

- State recommended changes to the proposed policy as a result of the impact assessment
- Where it has not been possible to amend the policy, provide the detail of any actions that have been identified
- Describe the plans for reviewing the assessment

No impact identified. See front sheet for review date

Guidance on Equalities Groups

<table>
<thead>
<tr>
<th>Race and Ethnic origin (includes gypsies and travellers) (consider communication, access to information on services and employment, and ease of access to services and employment)</th>
<th>Religion or belief (include dress, individual care needs, family relationships, dietary requirements and spiritual needs for consideration)</th>
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<tr>
<td>Disability (consider communication issues, access to employment and services, whether individual care needs are being met and whether the policy promotes the involvement of disabled people)</td>
<td>Sexual orientation including lesbian, gay and bisexual people (consider whether the policy/service promotes a culture of openness and takes account of individual needs)</td>
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<td>Gender (consider care needs and employment issues, identify and remove or justify terms which are gender specific)</td>
<td>Age (consider any barriers to accessing services or employment, identify and remove or justify terms which could be ageist, for example, using titles of senior or junior)</td>
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<tr>
<td>Culture (consider dietary requirements, family relationships and individual care needs)</td>
<td>Social class (consider ability to access services and information, for example, is information provided in plain English?)</td>
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If further assessment is required please see the Integrated Single Equality Scheme.

For advice in respect of answering the above questions, please contact Maria Crosbie, HR Manager, on extension 2552.
PROFORMA FOR RATIFICATION OF POLICIES AND GUIDELINES BY RATIFYING COMMITTEE

<table>
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<tr>
<th>Policy/Guidelines Name:</th>
<th>Guideline for the delivery of extremely premature babies</th>
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<tbody>
<tr>
<td>Name of Person completing form:</td>
<td>Women's Health Guidelines Group</td>
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<tr>
<td>Date:</td>
<td>March 2011</td>
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<tr>
<th>Author(s) (Principle contact)</th>
<th>Women’s Health Guidelines Group</th>
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<tbody>
<tr>
<td>Name of author or sponsor to attend ratifying committee when policy/guideline is discussed</td>
<td>Peter Reynolds Consultant Neonatologist</td>
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<tr>
<td>Date of final draft</td>
<td>March 2011</td>
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Has this policy/guideline been thoroughly proof-read to check for errors in spelling, typing, grammar and consistency? Yes

By whom: Women’s Health Guidelines Group

Is this a new or revised policy/guideline? revised

Describe the development process used to generate this policy/guideline. 

Who was involved, which groups met, how often etc.? 

Women’s Health Guidelines Group, Labour Ward Forum, Obs & Gynae Consultants, Paediatricians

Who is the policy/guideline primarily for? 

Health Professionals working within the maternity service

Is this policy/guideline relevant across the Trust or in limited areas? 

Maternity Services, NICU

How will the information be disseminated and how will you ensure that relevant staff are aware of this policy/guideline? 

Intranet, newsletters, educational half day, training sessions

Describe the process by which adherence to this policy/guideline will be monitored. 

(This needs to be explicit and documented for example audit, survey, questionnaire)

See monitoring section of policy

Is there a NICE or other national guideline relevant to this topic? If so, which one and how does it relate to this policy/guideline? 

See reference section of policy

What (other) information sources have been used to produce this policy/guideline? 

See reference section of policy

Has the policy/guideline been impact assessed with regard to disability, race, gender, age, religion, sexual orientation? 

No impact

Other than the authors, which other groups or individuals have been given a draft for comment? (e.g. staff, unions, human resources, finance dept., external stakeholders and service users) 

All obstetric Consultants, Women’s Health Guidelines Group, Labour Ward Forum, Neonatal Paediatricians

Which groups or individuals submitted written or verbal comments on earlier drafts? 

Any comments received considered by Women’s Health Guidelines Group

Who considered those comments and to what extent have they been incorporated into the final draft? 

All comments considered

Have financial implications been considered? 

Yes

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